Respect / Tolerance & Inclusion / Excellence

INCIDENT / INJURY / TRAUMA RECORD

This record should be completed as soon as practicable, but no later than 12 hours after the incident, injury or trauma.

NAME OF CHILD: _____ DOB: ____ / ____ / ____

EVENT: ☐ INJURY ☐ INCIDENT ☐ TRAUMA (please tick)

DATE OF EVENT: _____/ _____/ _____ TIME OF EVENT: _____ am/pm

CIRCUMSTANCES SURROUNDING THE EVENT:

ACTION TAKEN BY STAFF (INCLUDING FIRST AID, MEDICAL PERSONNEL NOTIFIED):

WITNESS DETAILS:

1.	Name:	Ph:
2.	Name:	Ph:

PERSONS NOTIFIED OR ATTEMPTED TO BE NOTIFIED:

1.	Name:	Date: ___/ ___/ ____ Time: _____am/pm
2.	Name:	Date: __ / _/ Time: _____am/pm
3.	Name:	Date: __ / _/ Time: _____am/pm

FORM COMPLETED BY:

Name:	Signature:
Name:	Time:

Parent Signature: _____ Date: _____ Time: _____